

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-022532

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 1539

STATE FILE NUMBER

FILED MAY 27 1963

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JEFFERSON BARRACKS, MO.		c. CITY OR TOWN ST. CLAIR	
Length of stay in lb 1 day		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS (If outside, give location) 785 RIDGE	
Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
3. NAME OF DECEASED (Type or print) First HOMER Middle J. Last CURTIS		4. DATE OF DEATH Month MAY Day 9 Year 1963	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/13/07
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (City and state or country) VICHY, MISSOURI
13a. FATHER'S NAME JOHN CURTIS		13b. MOTHER'S MAIDEN NAME SARAH DANIELS	14. NAME OF HUSBAND OR WIFE ELLEN CURTIS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES 1/26/42 to 10/25/45		16. SOCIAL SECURITY NO. 785 Ridge St. Clair, Missouri	
17. INFORMANT ELLEN CURTIS		Address 785 Ridge St. Clair, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE CEREBRAL VASCULAR HEMORRHAGE DUE TO (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) HYPERTENSIVE CARDIO-VASCULAR DISEASE and PULMONARY EMPHYSEMA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH 12-24 HOURS 12-24 HOURS LONG STANDING
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour VA Month, Day, Year 5/8/63	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION St. Clair, MO.	
21. attended the deceased from 5/8/63 to 5/9/63 Death occurred at 2:25 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE John J. Mueller M.D. (Degree or title)	
22b. ADDRESS VET. ADM. HOSP., JEFF. BRKS., MO.		22c. DATE SIGNED 5/9/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/12/63	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	23d. LOCATION (City, town, or county) (State) Lonedell, Mo.
24. FUNERAL DIRECTOR Casey-Lenox F.H. ADDRESS St. Clair, Mo.		25. DATE RECD. BY LOCAL REG. 5-11-63	
26. REGISTRAR'S SIGNATURE John H. Murphy M.D.			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed B. M. Leroy

Licensed Embalmer No. 3601

P. O. Address St. Charles, MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.